

Chapter 4

Nomadic Clinics as Innovative Concept that Transforms Health Care Services in Mobile Population: Case Example from North Eastern Kenya

Siyat Moge Gure
Ministry of Health, Kenya

ABSTRACT

Nomads have the shared habit of migrating from one area to another. They contribute enormously to the economic development of the world. In Kenya's North Eastern counties, 60-70% of the population practices nomadic pastoralists. These counties has the poorest health indicator as a result of inadequate strategies in extending conventional health care to the nomadic population. In an effort to address this, a unique health delivery model dubbed 'nomadic clinic'; was unveiled. An evaluation study was carried out to assess access, utilization, impact and cost- effectiveness of the clinic as well as to establish the community and staff perceptions on health service it provides. This was done in comparison to three static health facilities. Nearly all assessed indicators favoured the nomadic clinics. However, the mobile clinics faced myriad of challenges principally due to resource constraints. Fortunately, the new devolved system of governance provides unequivocal opportunities.

INTRODUCTION

Kenya, just like many developing countries is a resource –scarce state with weak health infrastructure that led to poor health indicators. North Eastern Province (NEP); currently subdivided into three distinct counties, thanks to the new constitution that adopted devolved system of governments, is predominantly inhabited by the Somalis who also spread across several other horn of Africa countries- Ethiopia, Djibouti and Somalia. NEP which shares border to Somali republic to the east and Ethiopia to north is typically

DOI: 10.4018/978-1-4666-8702-8.ch004

an arid and semi-arid land and is estimated to have a population of 2.3 million (census 2009). 60-70% of the population is said to be living pastoral life with the remaining population concentrated in commercial centres (Muriithi and Mwanthi, 2005). Rearing of camels, goats, sheep and cattle is the main source of livelihood (Boussery et al 2009). Due to effect of climate change that increased the intensity and frequency of the drought, the livelihood of the community in these counties are in jeopardy. Kenya's Central Bureau of Statistic (n.d) estimates 65% of the Province residents live below poverty line, way below the national average of 46%.

As is the trend in most nomadic settings worldwide, health care in NEP was largely delivered through static health facilities that are mainly based in large trading centres (Boussery et al 2009). Save for some inconsistent and poorly planned outreach/mobile health services, the nomadic population in the NEP had no proper strategy to access conventional health care (Boussery et al 2009). This resulted low coverage of health services to a larger population of the province thus making the health indicators of the province lower than the national average (Boussery et al 2009). According to the last Kenyan Health Demographic Survey - 2008 (KDHS, 2008), immunization coverage of NEP was 37% while that of national stood at 78%. Hospital delivery was stated to be 17% (43% nationally). Literally, the province records worst health indicators compared to the national average, save HIV prevalence, which is lowest nationally. This clearly showed a big disparity within the nation, an attributable and indication of correlation with communities lifestyle – nomadic versus settled.

This chapter seeks to showcase a new approach that aims to reach the nomadic population with health care services through an innovative and unique model dubbed *nomadic clinic*. The objective of the chapter is to discuss the operations of the nomadic clinic that is designed to fit into the nomadic lifestyle and moves according to their seasonal migratory pattern. In the process, the clinics provide the nomads with wide range of integrated health services that includes disease prevention, health promotion and curative health services. The result of an evaluation study carried out to comparatively assess the nomadic clinic performance in relation to a static health facilities that provide a similar functions is also be discussed. The chapter further outlines the challenges encountered in the implementation of the model and will endeavour to front some remedial steps that are hoped to reduce and mitigate some of the administrative issues faced by the clinics.

BACKGROUND

Across the world, nomads, especially the pastoral life, have the shared habits of wandering in the wilderness in pursuit of water and pasture for their animals with little understanding of the conventional health care systems (Gure, 2013). Historically, whether by design or otherwise, nomads are disadvantaged and disenfranchised in many sphere of their lives including health and education (Harragin, (n.d.), Carr-Hill and Peart, 2005, Sternaugen, 2013, Cohen, 2005). Nomads are often blamed for not taking their health as a priority as they rarely consider many critical health conditions where in real it may be detrimental their health (Sachder, 2012, Helander, 1990). Many adages among the Somali pastoralists construe that the interest of their animals supersedes that of their own health. However, because of the cultural attachment to the animals and 'enslavement' to their habits in nomadic livelihoods (Sternaugen, 2013, Helander, 1990, Sachder, 2012), a nomad could be excused to behave in a manner that suits his lifestyle. Sheikh and Velema (1999) explain that "nomads are open to modern health care on condition that it is not an instrument to control them but something they control themselves". Others (Harragin (n.d.)

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